Abbey Healthcare (Cromwell) Ltd

Cromwell House Care Home

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 May 2015. We found breaches of three legal requirements. These were in relation to the administration of medicines, staffing levels at night and the management of people's health conditions.

After our comprehensive inspection on 19 May 2015, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches that were made.

We undertook this unannounced focused inspection on 5 November 2015. This was to check that the provider had followed their plan and to confirm that they now met legal requirements. We found that the provider had followed their plan which they had told us would be completed by the 1 October 2015 and that legal requirements identified during our inspection on 19 May 2015 had been met.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cromwell House Care Home on our website at www.cqc.org.uk.

Cromwell House Care Home is a three storey building located in the town of Huntingdon. The home provides accommodation for up to 66 people who require nursing and personal care. At the time of our inspection there were 51 people living at the home accommodated in single occupancy en suite rooms. The home is made up of three main units where people are cared for according to their assessed care or nursing needs.

The home did not have a registered manager in post. The current manager who had worked at the home since August 2015 was in the process of applying to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst action had been taken regarding the safe administration and recording of people's medicines since our last inspection we found further improvements were required with regard to the management and control of some people's medications.

Action had also been taken regarding the number of staff on duty during the night as well as new staff appointments in the posts of clinical lead and senior care staff.

Actions had been taken to identify, manage and improve the management of people's health conditions.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

The provider had put measures in place to ensure people were safely administered their medications. However, improvements were required on the management and control of people's medicines.

Additional night staff had been provided to meet people's assessed needs. New staff appointments had been made for clinical leads and senior care staff. However, there were some further improvements required in the deployment of staff at lunch time.

While some improvements have been made we have not revised the rating for this key question: to improve the rating to 'Good' would require a longer term track record of consistently monitoring the quality of the service and delivery of high quality care.

We will review our rating at the next comprehensive inspection.

Is the service effective?

Requires improvement

We found that action had been taken to ensure the service was effective.

People were provided with appropriate and effective support with their health conditions.

This meant that the provider was now meeting the legal requirements.

While improvements have been made we have not revised the rating for this key question: to improve the rating to 'Good' would require a longer term track record of consistently monitoring the quality of the service and delivery of high quality care.

We will review our rating at the next comprehensive inspection.

Cromwell House Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Cromwell House Care Home on 5 November 2015. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 19 May 2015 had been made.

The focused inspection was undertaken to check that the management of the home had systems in place to improve the staffing levels at night, the safe administration of people's medicines and the effective management of people's health conditions.

The inspection team inspected the service against two of the five questions we ask about services: is the service safe and is the service effective. This was because the service was not meeting some legal requirements in relation to these questions.

This unannounced focused inspection was completed by two inspectors, a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in dementia care.

Before the inspection we looked at all of the information that we held about the home. This included information from a local authority contracts manager and from the provider's action report, which we received on 1 July 2015, and information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

During the inspection we spoke with 12 people, four people's relatives and a visiting health care professional. We also spoke with the manager, the clinical lead, a senior care staff two registered nurses, three care staff, and an activities coordinator.

We looked at five people's care and health care management records. We observed people's care to assist us in our understanding of the quality of care people received.

We looked at people's medicines administration records and records in relation to the management of the service such as staff meeting minutes, people's dependency assessment records, audits and quality assurance checks.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Cromwell House Care Home on 19 May 2015 we found that the people were not always supported to have their needs met by a sufficient number of staff during the night.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our focussed inspection of 5 November 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 18 described above. However, we identified some areas which required further improvement.

The manager showed us the dependency tool they used and how each person's staffing needs were determined. We saw that the numbers of staff who were working, during the inspection, corresponded to the numbers of staff who should have been employed according to this dependency tool. There was now an additional member of staff on the second floor as well as better availability at night of a floating member of staff.

At this inspection, most people, relatives and staff we spoke with were satisfied with the staffing levels throughout the day and night and that their needs were met. One person said, "I understand if I have to wait occasionally. The staff tell me the reason for this if someone's needs are more urgent than mine." Another person said, "If I use my call bell they [care staff] come pretty quickly. I rarely have to wait more than a few minutes, if that." A relative told us, "I pressed the call bell the other day for my [family member] and the staff came straight away and asked what the matter was." A third person said, "The staff are usually quite busy but they get to you as soon as they can." They do remarkably well and I have no complaints about the number of staff."

Call bells were generally answered within a few minutes, but on the first floor this was not always the case. However, there were two occasions when we had to inform staff that people were waiting for their care needs to be met. This was as a result of staff cancelling call bell requests. One person said, "I sometimes sit for more than half an hour on the toilet with my bell ringing waiting to come out – or I might sit for half an hour with my bell ringing waiting to go in to the toilet." The second person told us they had had to wait two hours to be supported with ongoing health condition.

People who chose to eat in their rooms or in the dining rooms were supported to eat their lunchtime meal at the same time. People were being encouraged to eat their lunch in the main dining room. This meant that some people were brought to the dining room at 12.30pm and were still sat there at 13.55pm being supported by only one member of staff. This member of staff was trying to assist nine people who required some support to eat their meal. Whilst additional care staff assistance was eventually provided this was not until nearly the end of the lunchtime which meant people had been sat waiting for the support they required support. One person who had been waiting for their pudding said, "Come on – you lot are wasting my time." Eventually they got up and left the dining room without any pudding. This meant that the deployment of staff resource at lunchtime was not as effective as it should have been.

People's hygiene and continence needs were met. People told us and we found that there were a sufficient number of staff to meet their assessed personal care needs. One person said, "The staff help me to get up as I need two staff. They [care staff] always make sure I don't go anywhere without them." The manager and staff confirmed that the additional staffing levels had resulted in better availability of staff when they were requested. For example, if one floor was experiencing a particularly busy period staff would be relocated to assist where needed.

One relative said, "It is not just the number of staff but also the quality of them. All I can say is that they are all amazing." The clinical lead and the manger confirmed that staff turnover had reduced significantly. One relative said, "My family member knows most of the staff and often tells me about them whenever I visit. It is good to know my [family member] is being looked after."

At our comprehensive inspection of Cromwell House Care Home on 19 May 2015 we found that the people were not always protected against the risks associated with unsafe administration and recording of some people's medicines.

This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our focussed inspection of 5 November 2015

Requires improvement

Is the service safe?

we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above. However, at this inspection on 5 November 2015 we identified two further breaches.,

At this inspection nursing staff adhered to good infection preventing and control standards with regular hand sanitisation. We saw that prior to administering people's medicines that staff checked to ensure the person's identity matched the records for that person.

We looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines. The manager told us that there was a plan to reassess the competence of all staff administering medicines during November 2015. This was part of the manager's improvement plan as well as ensuring that all staff with responsibility for administering medicines had the correct skills and competences. One person told us, "The staff get my medicines out and ready for me and make sure I take them too." We noted that staff followed safe procedures when giving people their medicines. Staff told us that the medicines round took about two and a half hours every day. People would only receive further medicine when the appropriate time had elapsed between doses.

Medication records did not confirm that people were receiving their medicines as prescribed. When we compared medication records against quantities of medicines available for administration we found numerical discrepancies and gaps in records of medicine administration including records for the administration of medicines prescribed for external application. Some people's health and wellbeing was being put at risk because their medicine was unavailable. For example, a person who was scheduled to have a medicine to aid sleep the night before our inspection had not been administered their medicines. Another person had not been administered their painkiller tablets between 25 -29 October 2015. This was because their medication hadn't been obtained in time.

This was a breach of Regulation 12.2 (f). The service did not ensure that there were sufficient quantities of medicines to ensure the safety of service users and meet their needs.

Supporting information was available alongside medication administration record charts to assist staff when administering medicines to individual people including personal identification and information about known allergies and medicine sensitivities. However, where charts were in place to record the application and removal of skin patches, recording of blood glucose levels we found gaps in the records. When people were prescribed medicines on a when required basis, there was sometimes but not always written information available to show staff how and when to administer these medicines. For one person prescribed a medicine in this way, records showed that the medicine had been administered but there were no records explaining why the medicine was needed. Therefore people may not have had these medicines administered appropriately.

We saw that a person with limited capacity to make decisions about their own care or treatment was having their medicines administered to them crushed in food (covertly) without their knowledge. There were no records showing a best interest decision had been made by staff on their behalf which included written guidance for staff to refer to about administering medicines to the person in this way. Staff told us and we found there was no recorded evidence which showed that a pharmacist or GP had been consulted. This was to ensure that people's medicines could be administered in food. Improvements were needed to ensure medicines were stored safely and securely for the protection of people who used the service. People were at risk of being administered medications that was not undertaken in a lawful way.

This was a breach of Regulation 12.2 (b) The service did not protect service users against the risks of them receiving medicines which was not always in their best interest and in accordance with the MCA 2005.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of Cromwell House Care Home on 18 May 2015 we found that risks to people and their health were not always managed in a safe way.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our focussed inspection of 5 November 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above.

People told us that staff were prompt in making health care referrals. One person said, "I need my wound dressed and looked at regularly and this is what happens." Care plans we looked at and staff we spoke with confirmed that people who were identified of an increased risk to their health had their weight monitored at least weekly. We saw that appropriate and timely referrals had been made to health care professionals such as a dietician, speech and language therapist and tissue viability nurse. This was to support people with safe eating and drinking and maintain their skin condition. People could be confident that there were measures in place to help ensure that any change in health condition would be responded to promptly.

Staff told us that the training and supervisions they had completed since our May 2015 inspection had enabled them to understand people's healthcare needs much better. One said, "I have now had a clinical supervision. This has helped me understand my role much clearer and respond to any change in people's needs straight away." We saw that the timings for people's wound dressing changes were mostly adhered to. However, we found that the reasons for deviating from the timings were not always recorded or if the person had requested a change of time due to their personal preference. This meant that the risk assessment for managing people's wounds were not as up-to-date as they should have been.

Where people had been identified as being at an increased risk of developing a pressure sore, we found that the appropriate health care professional had been involved. We saw that advice for the repositioning of people cared for in bed, or those people who required assistance to move in their chair, was followed appropriately. Staff told us and records we looked at confirmed this. People's health and skin condition was regularly monitored and reviewed. However, not all people's wound care records were as up-to-date as they should have been. This meant that at a shift or staff change the nursing and care staff would not have all the information they should have had. Staff told us that they would address this recording issue straight away.

We observed nursing staff assisting people. Nurses ensured that people were aware of any healthcare support and what this was for as well as any future appointments to see health care professionals such as the person's GP or physiotherapist. One person said, "If I need a doctor I just ask and they come and see me. There is always a visit [by a GP] at least once a week."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12.2 (f) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment** **How the regulation was not being met:** **The service did not ensure that there were sufficient quantities of medicines to ensure the safety of service users and meet their needs.**

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Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12.2 (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment** **How the regulation was not being met:** **The service did not protect service users against the risks of them receiving medicines which was not always in their best interest and in accordance with the Mental Capacity Act 2005.**